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Short-term psychosomatic treatment of sexual problems

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SUMMARY This is a review of 172 couples presenting with psychosexual problems. Ninety-four per cent of couples treated showed improvement after a mean time of 2·1 hours with the doctor. Older patients and those with longstanding problems showed lower rates of improvement. It is suggested that if such problems are treated it may help to reduce the rate of sexually transmitted diseases.

Introduction

Psychosexual problems in marriage encourage extramarital contact which contributes to the rates of sexually transmitted diseases (STDs). With sympathy and encouragement sexual problems can be brought to light in STD clinics.

Friedman (1962), Courtenay (1968), and Tunnadine (1970) have described the psychosomatic approach used in short-term counselling of couples with sexual difficulties. This review was undertaken to find out if such methods are useful.

Patients and methods

One hundred and seventy-two consecutive couples referred to a psychosexual problem clinic were managed personally at each attendance. Table 1 shows the sources of referral, Table 2 the ages of patients, and Table 3 the duration of their problems.

In psychotherapy emphasis is placed on:

The doctor patient relationship

The emotions generated in the doctor through interaction with the patient are used as a diagnostic and therapeutic tool.

Table 1 *Sources of referral of* 172 *couples*

	No.	*%*
Family planning clinics	134	78
Own accord	16	9
General practitioners	14	8
Clinic for sexually transmitted diseases	4	2·5
Other	4	2·5

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Table 2 *Age distribution of members of* 172 *couples*

	Age in years 15–25		26–35		36–45		46+		*Not known*	
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Women	67	39	72	42	22	13	9	5	2	1
Men	48	28	81	47	28	16	12	7	3	2

Table 3 *Duration of problem of* 172 *couples before first visit*

	Duration in years 1	1–4	5–8	9–12	13%	*Not known*
No. of couples	9	95	30	20	14	4

The unstructured interview technique

The patient is encouraged to talk freely about his problem and feelings. With some prompting by the doctors he or she brings to the surface significant emotional problems. Question-and-answer techniques often hide those feelings that are important.

Uncovering and interpreting the patients' fantasies

The patient is helped to describe ideas and attitudes about physical facts and processes. Erroneous ideas may contribute to the problems.

Genital examination

Vaginal examination by doctor and patient enables the female patient to come to terms with reality rather than indulge in fantasies she has about her genitals. Genital examination of the male also helps —hence the term psychosomatic therapy.

Results

The problems found could be classified as follows:

1. Non-consummation. Partnerships in which vaginal penetration had not taken place (15 couples).
2. Primary frigidity. Partnerships where the woman had never enjoyed sexual intercourse (50 couples).
3. Secondary frigidity. Partnerships in which the woman had originally enjoyed sexual intercourse but had now lost her libido (52 couples).
4. Male or female general sexual dysfunction. These were partnerships in which the man or woman resisted sexual advances, or sought to avoid intercourse, but had some capacity to enjoy the act when encouraged (24 couples).
5. Female orgasmic difficulty. Partnerships in which the main complaint was the woman's inability to reach orgasm (9 couples).
6. Male impotence. Partnerships in which there was any degree of erection failure or in which premature ejaculation was a problem (14 couples).
7. The untreated. Partnerships in which the presenting condition was considered unsuitable for the type of short-term therapy employed (8 couples), see Fig. 2.

Figure 1 shows the degree of therapeutic involvement of the partners. The time spent on assessing and treating the 172 couples was 372 hours (558 visits of about 40 minutes each). The mean number of visits per couple was 3·2 with an average total time of 2·1 hours.

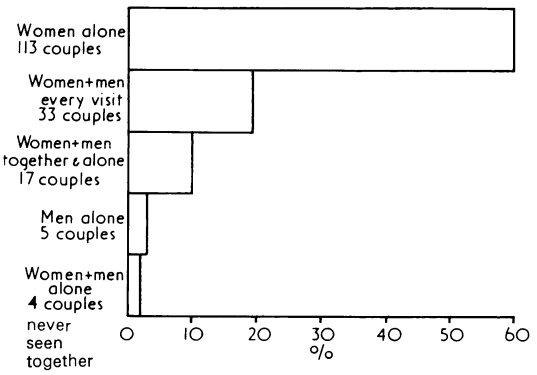

Fig. 1 172 *couples with psychosexual problems. This shows which partners attended treatment*

ILLUSTRATIVE CASES

Case 1. *Non-consummation*

The patient, a small dowdy 24-year-old woman, stated that her husband had left her after one year of marriage. He later divorced her because she had been unable to have sexual intercourse. Now, four years later, she wished to marry again but was terrified in case the same disaster should occur. She was asked to undress for examination, but when the doctor approached she shook with fear, began to sweat profusely, and retreated to the top end of the examination couch. This behaviour prompted the doctor to ask who had attacked her and had produced such fear of the genital area. The patient related that when she was five years old her family doctor had come to the house once a week to insert a suppository. The procedure had hurt and terrified her.

After discussing her feelings, past and present, the patient was able to put one finger into her own vagina and was delighted to find this did not hurt. At her fourth visit she attended looking very attractive. Sexual intercourse had been achieved. She announced that she was soon to be married and that she was very happy.

This case shows that the emotions generated in the doctor/patient relationship aided speedy diagnosis. The use of the vaginal examination is apparent.

Case 2. *Primary frigidity*

This patient, a big handsome 41-year-old woman, complained that she was having difficulty with her Dutch cap, and that using a tampon was like sitting on a peg. It was suggested to her that sexual intercourse must be very difficult whereupon she started to weep. She said she had a block in her vagina.

It gradually became apparent that, while she enjoyed petting, as soon as intercourse began sexual feelings stopped and she beat her husband's shoulders with her fists. Her husband said her aggression at these times was uncontrollable and seemed to provide grounds for divorce. All this made the patient afraid that her husband would seek sexual intercourse with other women and perhaps contract venereal disease, or that he might leave her.

Her mother had hated sex. As a child she had heard her parents argue and shout in bed. These quarrels had upset her from the age of nine onwards. Her sister had fainted when she first had sexual intercourse and subsequently attended a gynaecologist.

On vaginal examination, the patient was found to be normal. With encouragement she examined herself repeatedly and was surprised to find her vagina had no block. When she agreed that the block was in her mind, and that her symptoms were symbolic, she was able to discuss and understand her mother's cries and her sister's faint. After several interviews she was able to forget her fantasies.

This case illustrates the necessity of uncovering fantasies and helping the patient to accept and

interpret them. The usefulness of a vaginal examination is also apparent.

Case 3. Sexual dysfunction

When this 33-year-old man was found to have gonorrhoea, acquired extramaritally, he said he could not possibly bring his wife for investigation. He did not wish to upset a very good marriage. He was referred and given the opportunity and encouragement to talk freely. He stated that although he loved his wife he seldom had sexual intercourse with her because he felt tired, disinclined to participate, and because the act gave him little pleasure. His 34-year-old wife complained that she would like sexual intercourse more often and that she was longing for a child.

It emerged that when he was a boy his mother had taken him regularly to visit his older brother's grave, and he was very conscious that one of his mother's babies had died. When he was 16 years old an older sister became pregnant and felt obliged to marry, although the parents disapproved. Shortly after this, his mother had died. A second sister later married, became pregnant, died in childbirth and later her baby died. At about this time his grandmother also died. In the course of this recital, and its discussion the patient gradually realised that he was frightened of marital intercourse because he was terrified of his wife dying. With this insight he discussed the problem with his wife and the couple's problem resolved. There was no longer the need for extramarital intercourse.

A question-and-answer type of interview would have been unlikely to uncover the man's fantasy that childbirth is inseparable from death. The case illustrates the use of the unstructured interview and fantasy interpretations.

Diagnosis and outcome

Figure 2 shows the diagnostic classification and outcome of these 172 couples. With the exception of those over 46 years of age for whom results were poor, the rate of improvement was not related to age.

Table 4 *Rate of improvement of couples related to duration of problem*

Duration of problem (years)	*Improved*		*Not improved**		*Total*
	No. of couples	(%)	*No. of couples*	(%)	
1	9	(100)	0	(0)	9
1–4	71	(75)	24	(25)	95
5–8	22	(73)	8	(27)	30
9–12	14	(70)	6	(30)	20
13+	9	(64)	5	(36)	14
Not known					4

*Including defaulters and those not suitable for treatment

The improvement rate fell as the duration of complaint increased, see Table 4.

Of these 172 couples, eight were considered unsuitable for short-term treatment. Another 29 couples defaulted after only one visit. Figure 3 shows the outcome in the remainder in terms of very much improved, much improved, improved, and not improved.

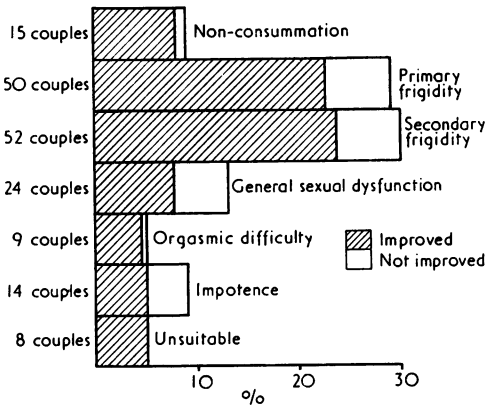

Fig. 2 *Diagnosis and outcome of treatment of* 172 *psychosexual problems*

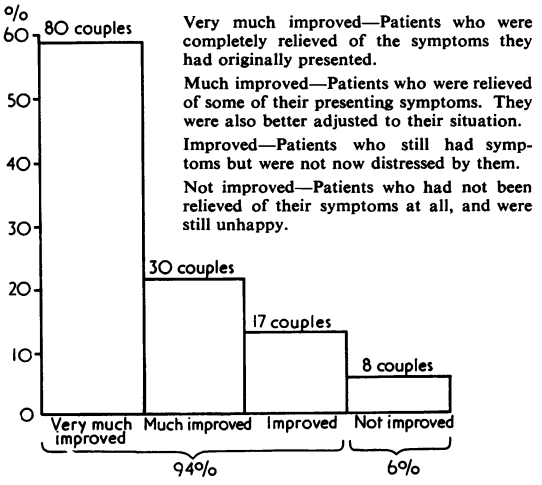

Fig. 3 *Outcome after treating* 135 *problems*

172 psychosexual problems
−29 defaulted after one visit
− 8 unsuitable
135

Discussion

It is appreciated that it is difficult to evaluate the success in treating psychosexual problems as related to the patient's initial and subsequent feelings and the doctor's subjective assessment, and more objective criteria are required. It should be pointed out, however, that in these patients such feelings are regarded as facts by both the doctor and patient. With these limitations in mind it can be said that of the 135 partnerships actually treated, 127 (94%) showed some degree of improvement. This improvement was greater in younger couples for whom these problems were of shorter duration.

The degree of improvement achieved by the number of visits by the patient and the time spent by the doctor compares favourably with the modified Masters and Johnson method described by Bancroft and Coles (1976). In their series of 78 (after excluding 86 problems as unsuitable), 58 patients (68%) improved while 25 (32%) showed no improvement or defaulted. The average number of visits in the series of Bancroft and Coles (1976) was eight with a total of five hours, as compared with 3·2 visits and 2·1 hours in the present series.

From this experience a sexual problem clinic within an STD department using psychosomatic rather than behavioural methods should provide a useful service at minimal cost and could help to prevent the spread of sexually transmitted disease.

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